WEB-BASED AUTOMATED RESPONSE SYSTEM (ARS) USER GUIDE

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GENERAL INFORMATION

The Automated Response System (ARS) User Guide is a joint publication by the Department of Medical Assistance Services (DMAS) and the First Health Services Corporation (FHSC). ARS provides twenty-four-hour-a-day, seven-day-a-week internet access to eligibility information, service limits, claim status, prior authorizations, provider check status and prescribing provider ID lookup (for pharmacy providers only). This web-enabled tool will help provide cost-effective care and allow quick, convenient access to information. Unlike MediCall (the voice response system), there are no limits to the number of inquires per session. Finally, this system has been redesigned and is HIPAA compliant.

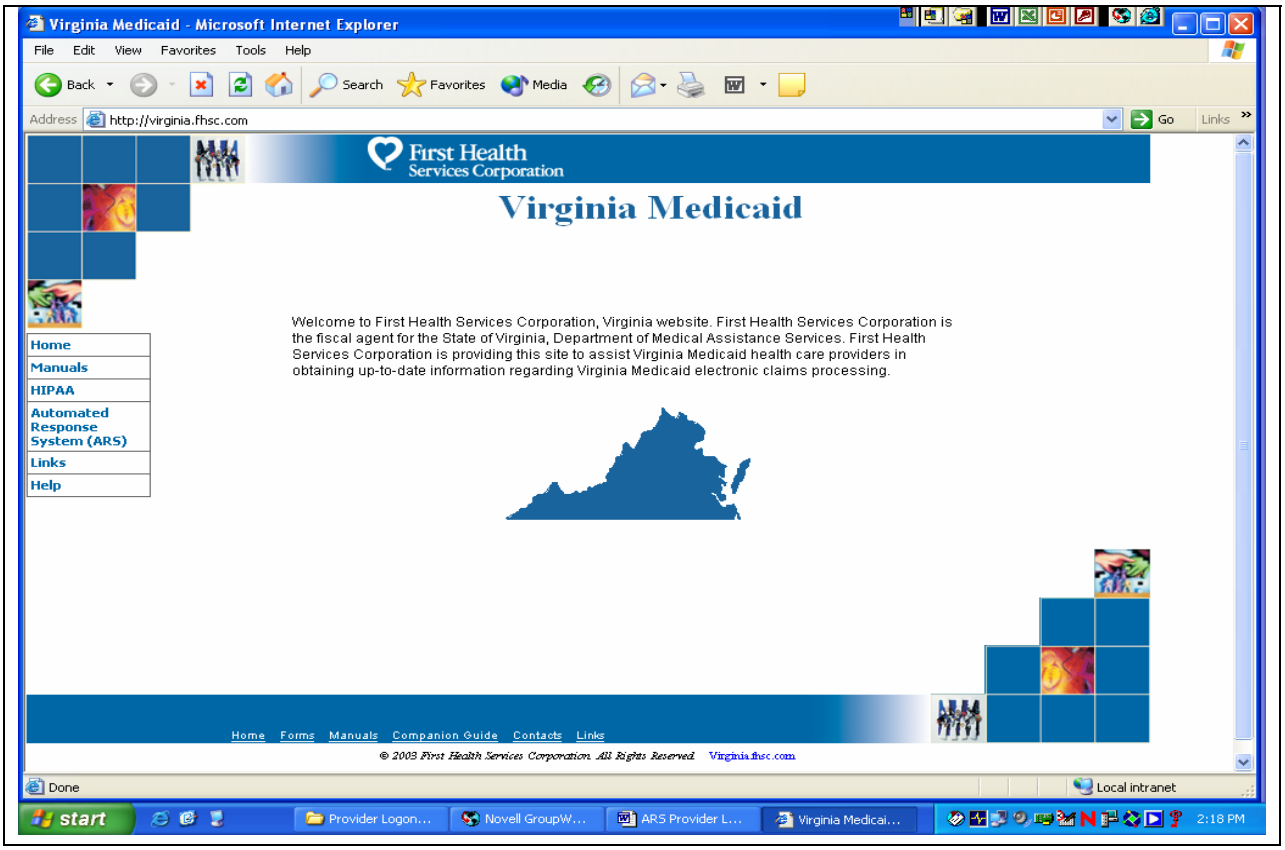
SCOPE

This manual provides basic instructions and screen prints for the registration, log-on and use of ARS. It provides detailed explanations of both the request and response screens for each function of ARS. The glossary and appendix provide supplemental information to aid in the interpretation of ARS data. This manual functions as a user guide, not as a technical document that explains how the computer system is designed and operates.

GETTING STARTED

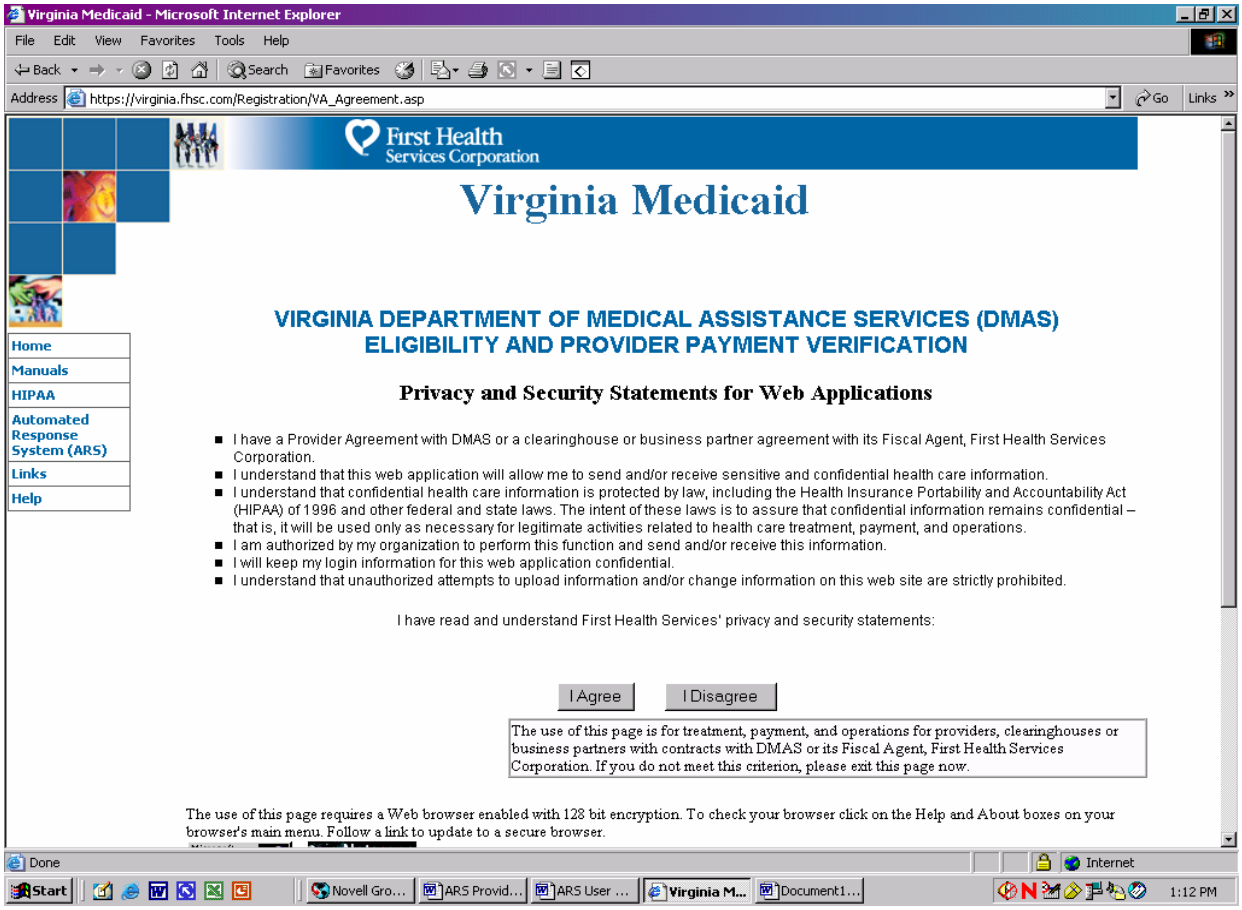
The ARS system can be used by anyone with an internet-connected PC, web browser and an active Medicaid provider number. The provider number is required as part of the log-on process. After going to the Virginia Medicaid web site at http://virginia.fhsc.com, move the cursor over the box that says “Automated Response System (ARS)” in a few seconds an additional menu will display. This menu offers three options. First time users need to select “Secure Registration.” If you are not a first time uses, select “Secure Logon.” Selecting “ARS Users Guide” will link you with a copy of this manual. The “FAQ” (Frequently Asked Questions) section answers general questions about ARS. FAQs are also available in this manual.

Below is a picture of the http://virginia.fhsc.com home page:



Secure Registration (First Time Users)

A new user must first register to use ARS. After selecting "Secure Registration," read the privacy and security statement and then select "I Agree" to continue with the registration process.

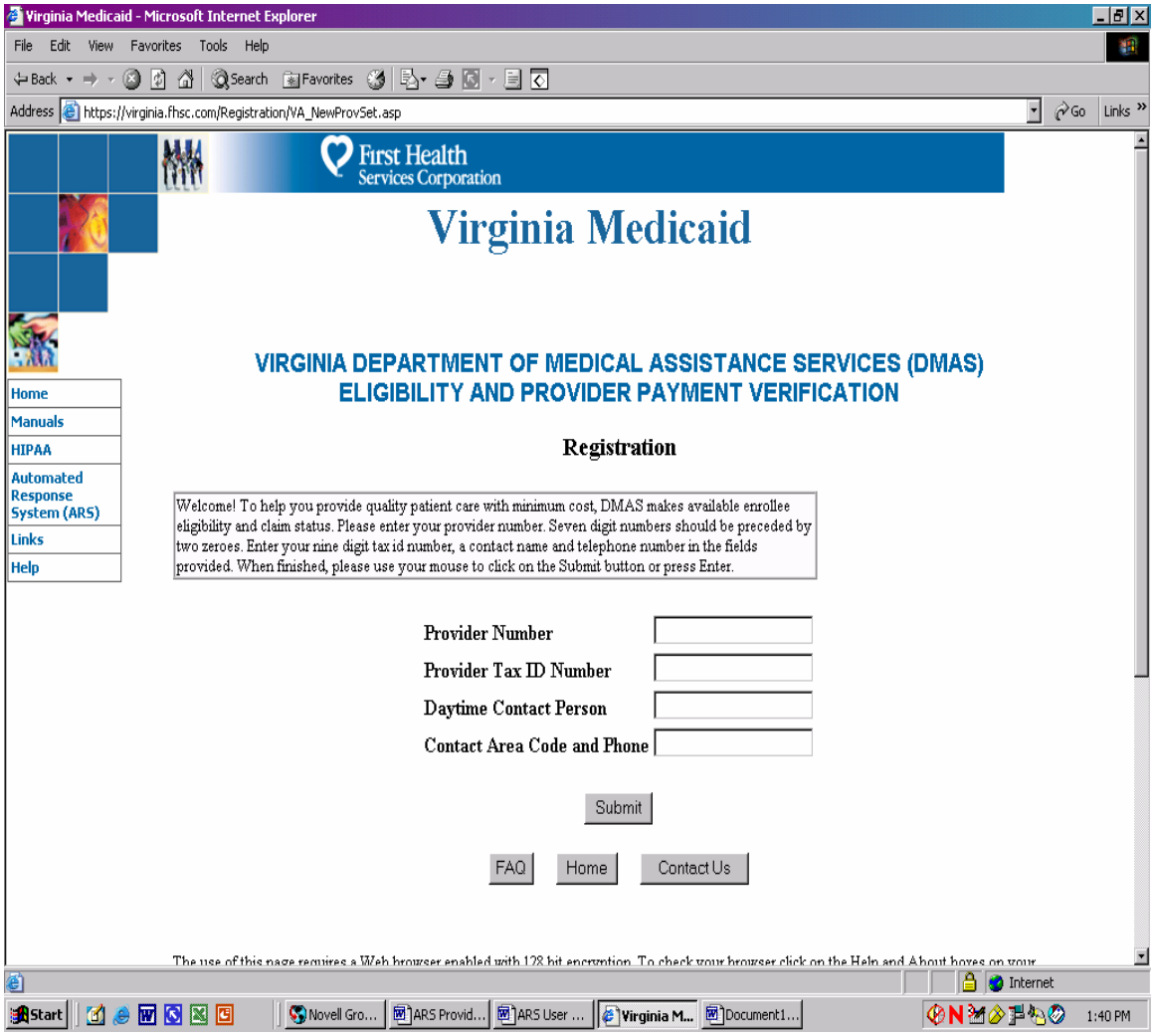


Complete the registration form and select "Submit." Within 72 hours the Web Support Unit (WSU) will call with a logon name and password. If the WSU does not call with in 72 hours, do not re-register. Instead, call the number below.

Questions about the registration process, can be directed to:

1(800) 241-8726 All local and long distance calls

NOTE: First time users are required to change the password that was assigned by the Web Support Unit. After logging on for the first time, a screen will display that prompts you to change your password. Enter the old password, a new password, and, for verification purposes, the new password again. Click the "Submit" button.



The “FAQ” button goes to a section that answers commonly asked questions about the logon process. “Home” takes the user back to the main menu, and “Contact Us” provides the WSU phone number.

Secure Logon (Registered Users)

Registered users will select "Secure Logon" from the "Automated Response System (ARS)" menu to begin an inquiry.

To logon, enter the 9-digit Medicaid provider number with the prefix "VA," for example VA999999999. For 7-digit provider numbers, enter the prefix VA00 -- VA009999999. Next, enter your password. Passwords are case sensitive; Therefore, if you initially register your password in all capital letters, you must continue to type it in capitals each time you log on.

ARS Logon Failure

If the logon fails, the following error message appears:

"Logon failed
Please try again"

Try the logon again. If the logon continues to fail, call the Web Support Unit at First Health Services Corporation at 1-800-241-8726

ARS Access Problems

The following message appears when there is a problem processing the session:

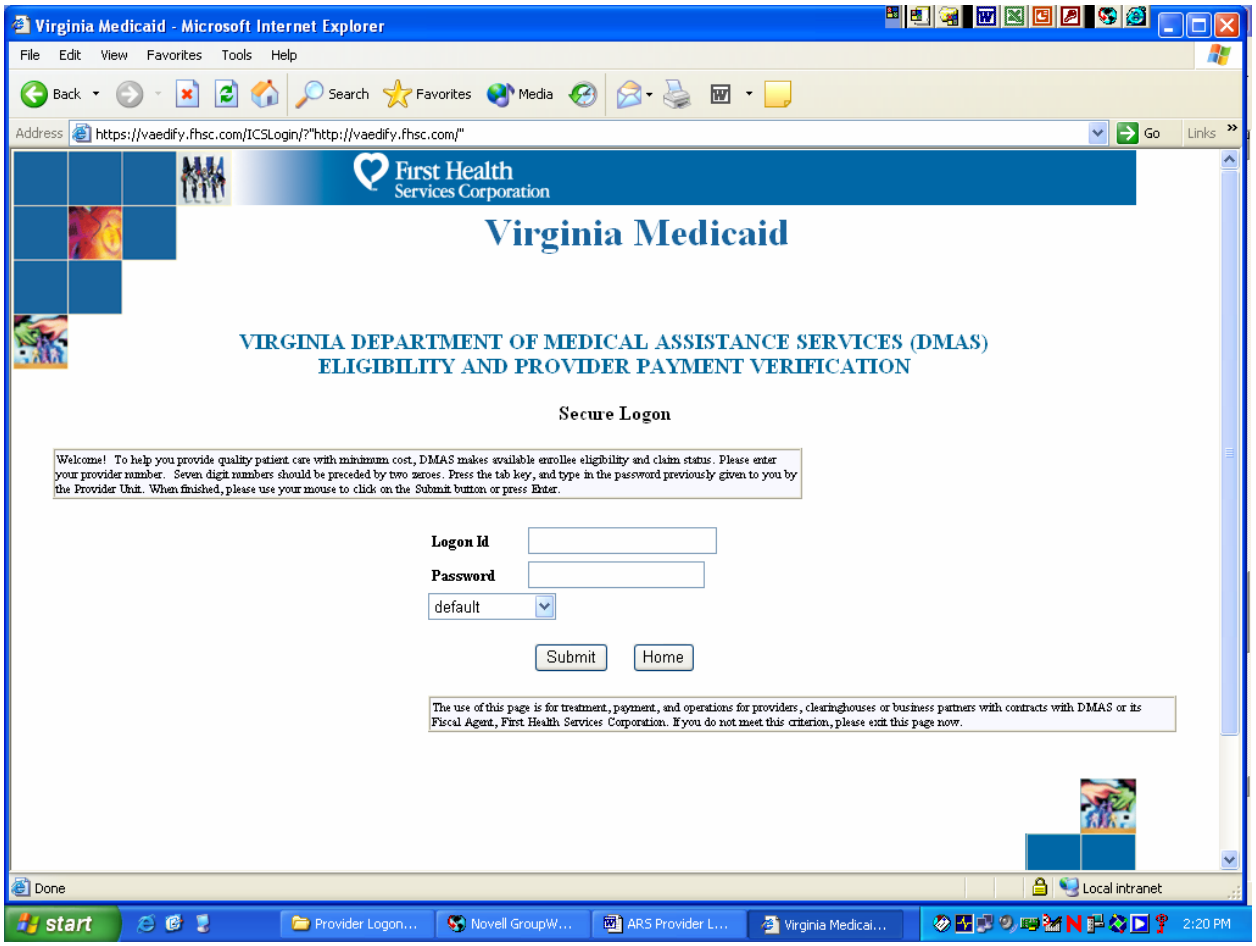
"Your interactive session cannot be processed at this time."

Possible Causes
In most cases you receive this message because all software agents are currently busy. Other possible causes of the problem include:

- Resources needed by the application could not be acquired at the time.
- The application you are trying to access is not running.
- The application you are trying to access has been changed.

Resolution
1. Reload the previous page and try again.
2. Try this application at a later time:
   – The best time to access ARS is in the morning before 10 A.M. and in the afternoon after 2 P.M. Mondays and Fridays are also better days to access ARS.

Below is a picture of the secure logon screen:

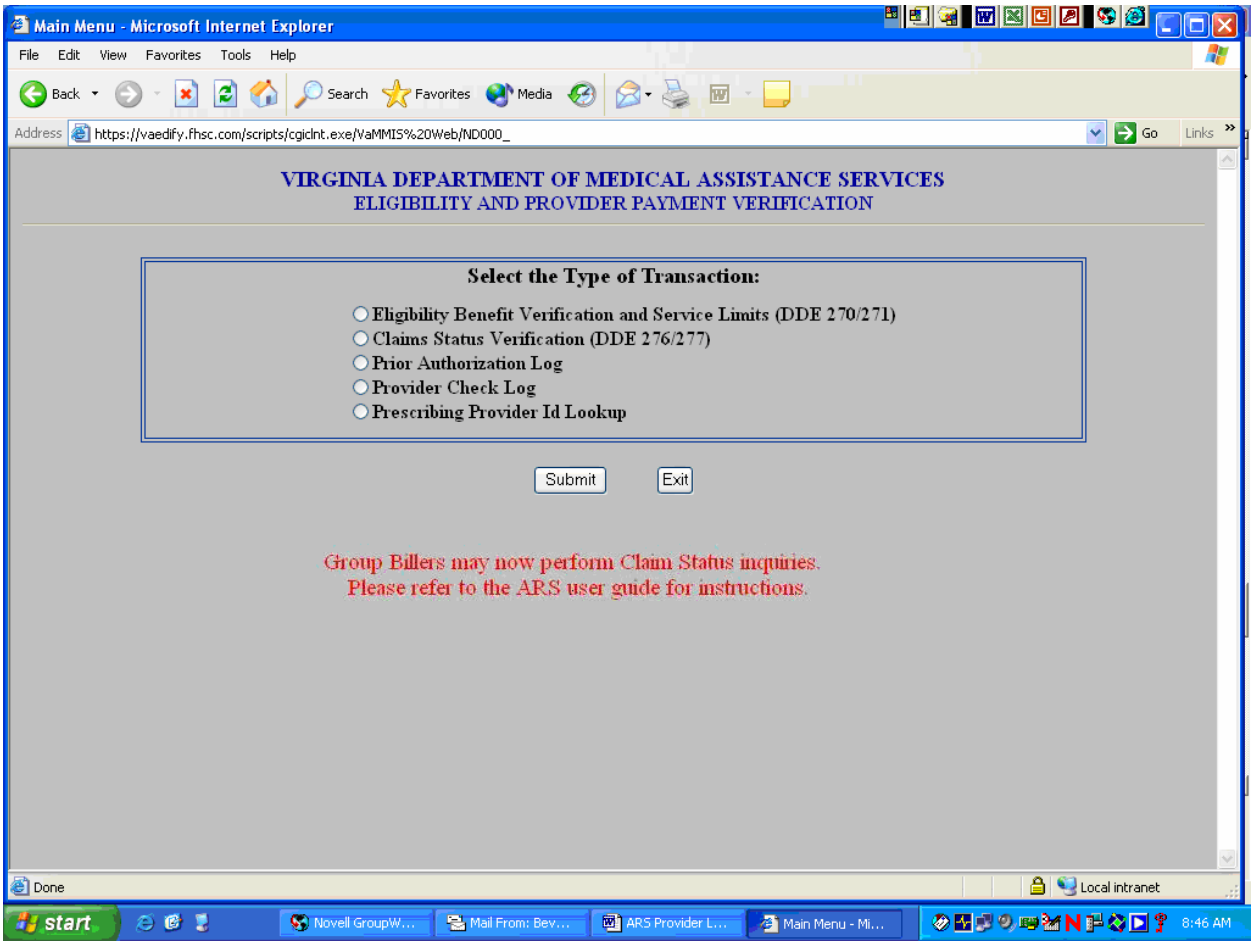


NOTE: For security purposes, passwords must be changed every 45 days.

USING ARS

Main Menu Screen

After logging on, the main menu screen appears. Depending on the type of provider, there will be either four or five choices. Below is a picture of the main menu screen:



NOTE: Only pharmacy providers have access to the Prescribing Provider ID lookup option. This option will only appear on the menu for those providers with a pharmacy provider ID.

Make a selection and click "Submit." A screen corresponding to that specific transaction will appear.

Selecting "Exit" on this screen will take you out of ARS.

1. Eligibility Benefit Verification and Services Limits

The next two screens are used to verify eligibility and service limits for a patient. The first screen will prompt you to provide enrollee identification information. The second screen returns eligibility and service limits data pertaining to the enrollee identified in the query.

1a. Request Screen:

When this option is selected from the main menu, you will be prompted for the following information:

- Enter the enrollee number (ID code) assigned by DMAS; OR
- Enter any two of the following:
  - Enrollee social security number (without dashes)
  - Enrollee date of birth (The first two fields hold a two-digit number for the month (MM) and day (DD), respectively. The third field holds a four-digit number for the year (CCYY))
  - Enrollee name (Middle initial is optional)

Regardless of which type(s) of enrollee identification you provide, you must include the service dates. Service dates cannot span more than one month. If the service date is only one day, enter the same day in both fields. The first two fields hold a two-digit number for the month (MM) and day (DD), respectively. The third service date field holds a four-digit number for the year (CCYY). The service "from" date must be within one year from the current date. Future service dates are not allowed.

Enter the provider's control or trace number. This is a tracking control number for internal purposes only. You are required to enter a value in this field. It can be a patient account number, a date and time, or any other alphanumeric code chosen by the provider to track this inquiry. This field will from accept from 1 up to 30 characters.

To receive service limit information, the service limit type must be selected from the "Service Type Code" drop down box. This is not a required field. It is to be used only by providers that fall into one of the following categories:

A1 – Substance Abuse
42 – Home Health Care (Home Health Aide)
43 – Home Health Visits (Skilled Nursing)
AD – Occupational Therapy
AE – Physical Medicine
AF – Speech Therapy
A8 – Psychiatric Outpatient

NOTE: For field definitions, hold the cursor over a field for a few seconds and a brief description will appear. This description states the type of information that is required for that field (e.g. alphabetical, numeric) and the total number of characters that can be entered. When entering data into a field, an alpha/numeric character appears. This is the HIPAA field name and will not affect the information that is being submitted. Ignore this character.

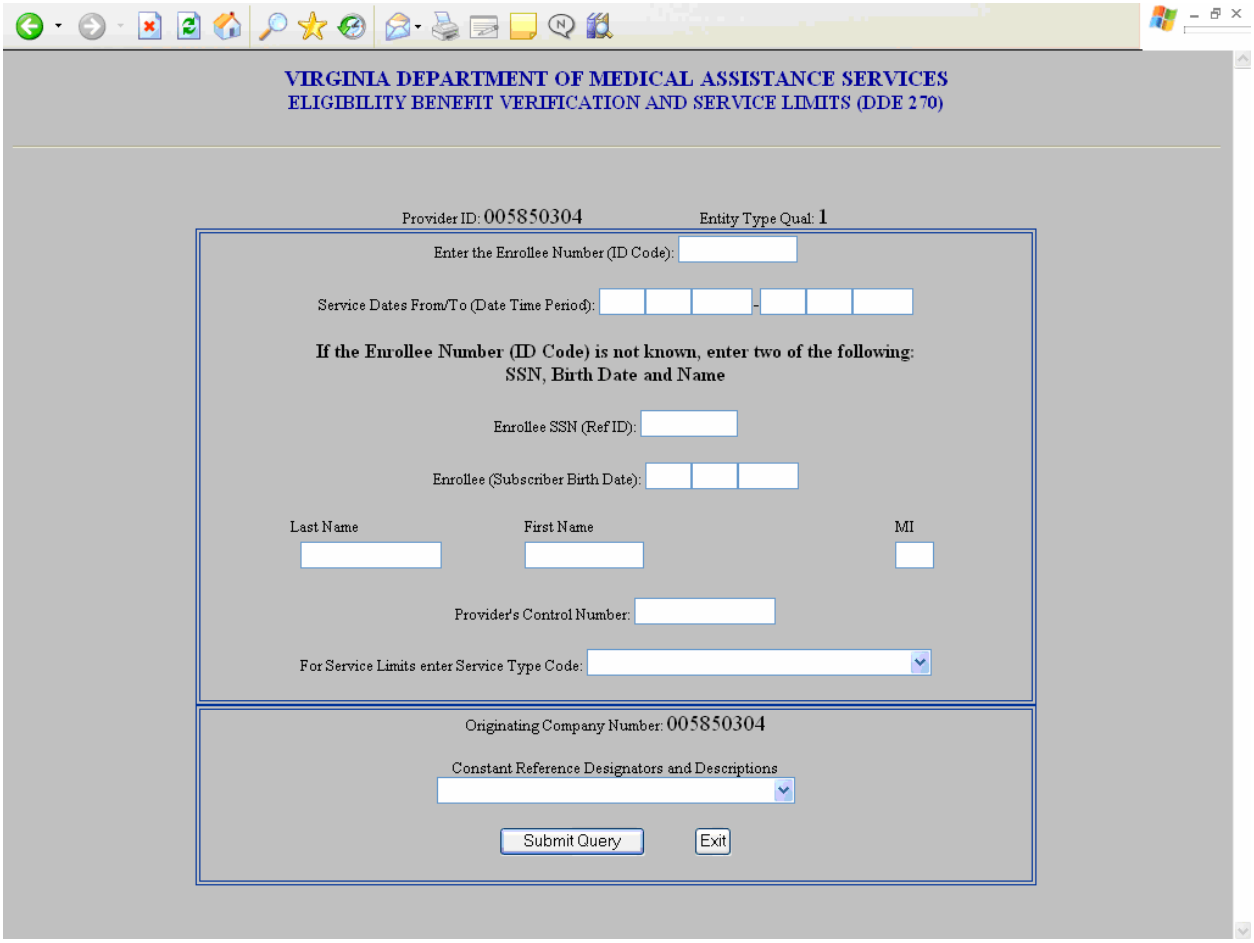
Please note that service limit categories for Substance Abuse and Psychiatric Outpatient services are only available to providers classified in our provider system as mental health practitioners.

The Constant Reference Designators and Description drop down menu displays the constant elements defined by the HIPAA 270/271 and 276/277 Implementation Guides. These fields are required in standard X12 transactions. They are not required to access the Eligibility and Provider Verification system and should be ignored.

Press “Submit Query” after entering the data. If any information entered is incorrect, a red error message will be displayed at the top of the form. Type in the correct information and resubmit.

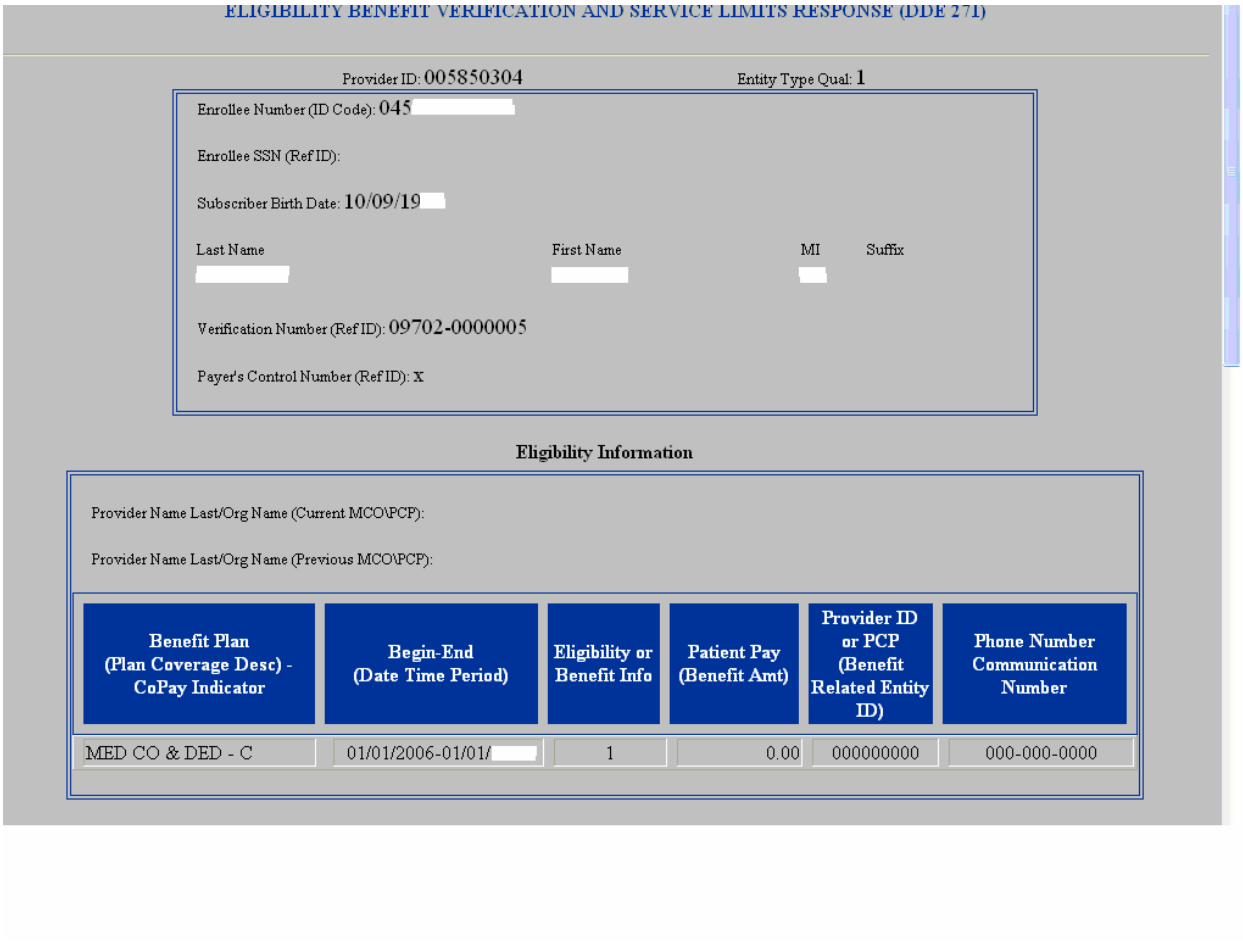
Selecting “Exit” on this screen will take you out of ARS.

Below is a picture of the eligibility screen:



1b. Response Section:

Below is a picture of the eligibility verification and service limits response screen:



ELIGIBILITY BENEFIT VERIFICATION AND SERVICE LIMITS RESPONSE (DDE 271)

Provider ID: 005850304 Entity Type Qual: 1

Enrollee Number (ID Code): 045

Enrollee SSN (Ref ID):

Subscriber Birth Date: 10/09/19

Last Name | First Name | MI | Suffix

Verification Number (Ref ID): 09702-0000005

Payer's Control Number (Ref ID): X

Eligibility Information

Provider Name Last/Org Name (Current MCO\PCP):

Provider Name Last/Org Name (Previous MCO\PCP):

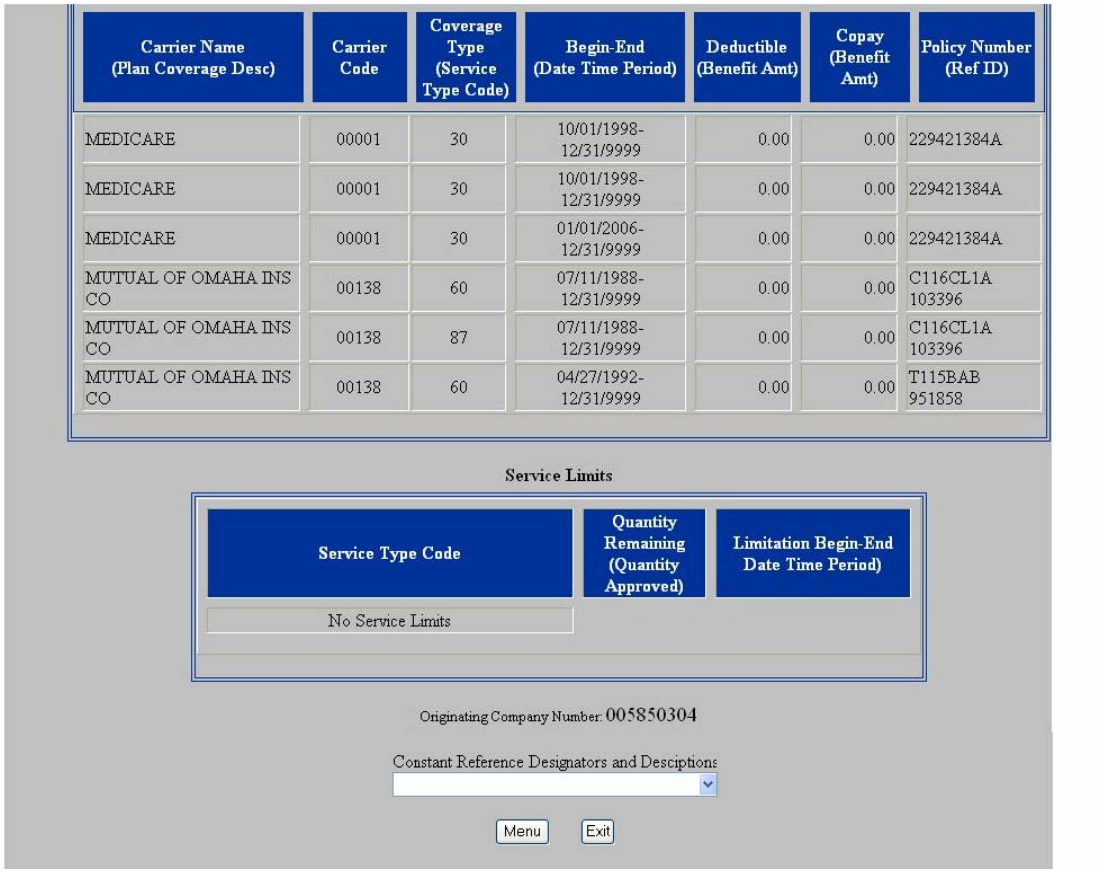
Benefit Plan (Plan Coverage Desc) - CoPay Indicator	Begin-End (Date Time Period)	Eligibility or Benefit Info	Patient Pay (Benefit Amt)	Provider ID or PCP (Benefit Related Entity ID)	Phone Number Communication Number
MED CO & DED - C	01/01/2006-01/01/	1	0.00	000000000	000-000-0000

The Eligibility Verification Response contains the Enrollees Number, SSN (if used in the inquiry), Subscriber Birth Date, Last Name, First Name, Middle Initial, and Suffix, the Verification Number (unique tracking number) and the Payer's Control Number (defined by the user in the eligibility request (DDE 270).

The Eligibility Information Section responds with the current and previous Managed Care Organization or Primary Care Physician information for the period inquired. It is IMPORTANT to note that the enrollees current benefits for the period inquired are found below in the blocks entitled **Benefit Plan (Plan Coverage Description) - Copay Indicator, Begin-End (Date Time Period), Eligibility or Benefit Information, Patient Pay, Provider ID or PCP, and Phone Number (if available)**. The complete list of Benefit Plans is found in Appendix A of this Guide. The CoPay indicator information is located in your Medicaid Provider Manual in Chapter III under the topic "Verification of Recipient Eligibility".

1b. Response Section Continued:

Third Party Liability (TPL) section of the eligibility verification provides the Carrier Name (Plan Coverage Description), the Medicaid Insurance Carrier Code found in your Medicaid Provider Manual Chapter III, Exhibits under the topic of Insurance Company Codes, the HIPAA compliant 271 Coverage Type Code (the HIPAA Implementation Guide can be purchased at http://www.wpc-edi.com), the Begin and End Dates of coverage on file for the insurance coverage, Copay and Deductible amounts on file, and the Policy Number.



Carrier Name (Plan Coverage Desc)	Carrier Code	Coverage Type (Service Type Code)	Begin-End (Date Time Period)	Deductible (Benefit Amt)	Copay (Benefit Amt)	Policy Number (Ref ID)
MEDICARE	00001	30	10/01/1998-12/31/9999	0.00	0.00	229421384A
MEDICARE	00001	30	10/01/1998-12/31/9999	0.00	0.00	229421384A
MEDICARE	00001	30	01/01/2006-12/31/9999	0.00	0.00	229421384A
MUTUAL OF OMAHA INS CO	00138	60	07/11/1988-12/31/9999	0.00	0.00	C116CL1A 103396
MUTUAL OF OMAHA INS CO	00138	87	07/11/1988-12/31/9999	0.00	0.00	C116CL1A 103396
MUTUAL OF OMAHA INS CO	00138	60	04/27/1992-12/31/9999	0.00	0.00	T115BAB 951858

Service Limits would be shown in the Service Limits Section if requested in the Eligibility Benefit Verification and Service Limits (DDE 270) request. Please note that only mental health providers will have access to enrollee psychiatric and mental health service limit information.

Selecting “Exit” on this screen will take you out of ARS.

2. Claims Status Verification

The next two screens are used to check on the status of a claim. The first screen will prompt you to provide information regarding a claim. The second screen returns claims status data pertaining to the claim identified in the query. Group Billing Practices of composed of individual physicians and practitioners can inquire on the status of claims billed by the group for servicing or rendering providers that are members of the group. A servicing or rendering provider or organization not associated to a Group Billing Practice will enter the ARS system as the billing provider to check the status of the individual's or organization's claims.

2a. Request Screen:

When this option is selected from the main menu, you will be prompted for the following information:

- Enter the Payor's Claim Control Number (ICN); OR
- Enter the enrollee number assigned by DMAS and the service dates:
  - Service dates cannot span more than one month. If the service date is only one day, enter the same day in both fields. The first two fields hold a two-digit number for the month (MM) and day (DD), respectively. The third service date field holds a four-digit number for the year (CCYY). The service "from" date must be within two years from the current date. Future service dates are not allowed.

You may also enter the servicing (rendering) provider ID number. If the billing provider's ID number is not provided, the search will default to the provider number used to enter the ARS.

Enter the provider's control or trace number. This is a tracking control number for internal purposes only. You are required to enter a value in this field. It can be a patient account number, a date and time, or any other alphanumeric code chosen by the provider to track this inquiry. This field will accept from 1 up to 30 characters.

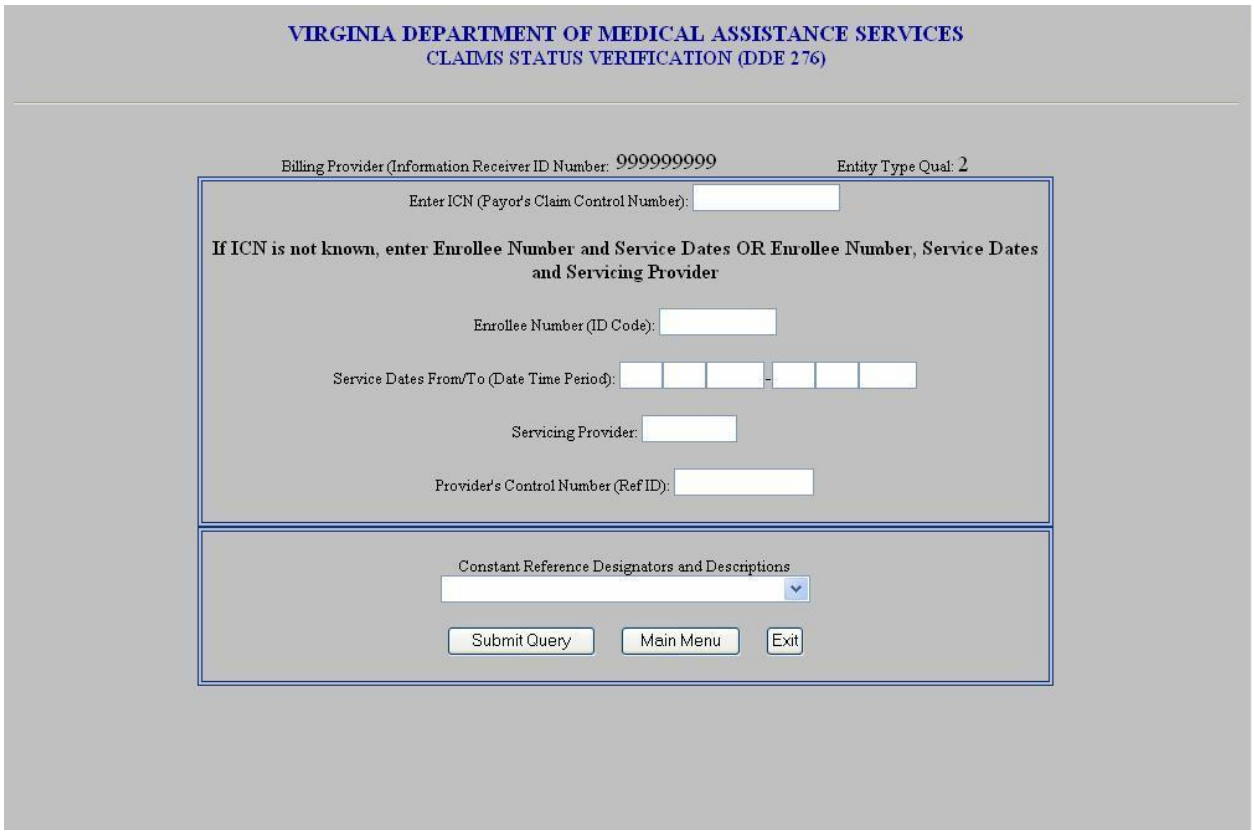
The Constant Reference Designators and Description drop down menu displays the constant elements defined by the HIPAA 270/271 and 276/277 Implementation Guides. These fields are required in standard X12 transactions. They are not required to access the Eligibility and Provider Verification system and should be ignored.

NOTE: For field definitions, hold the cursor over a field for a few seconds and a brief description will appear. This description states the type of information that is required for that field (e.g. alphabetical, numeric) and the total number of characters that can be entered. When entering data into a field, an alpha/numeric character appears. This is the HIPAA field name and will not affect the information that is being submitted. Ignore this character.

Press “Submit Query” after entering the data. If any information entered is incorrect, a red error message will be displayed at the top of the form. Type in the correct information and resubmit.

Selecting “Exit” on this screen will take you out of ARS.

Below is a picture of the claims status request screen:

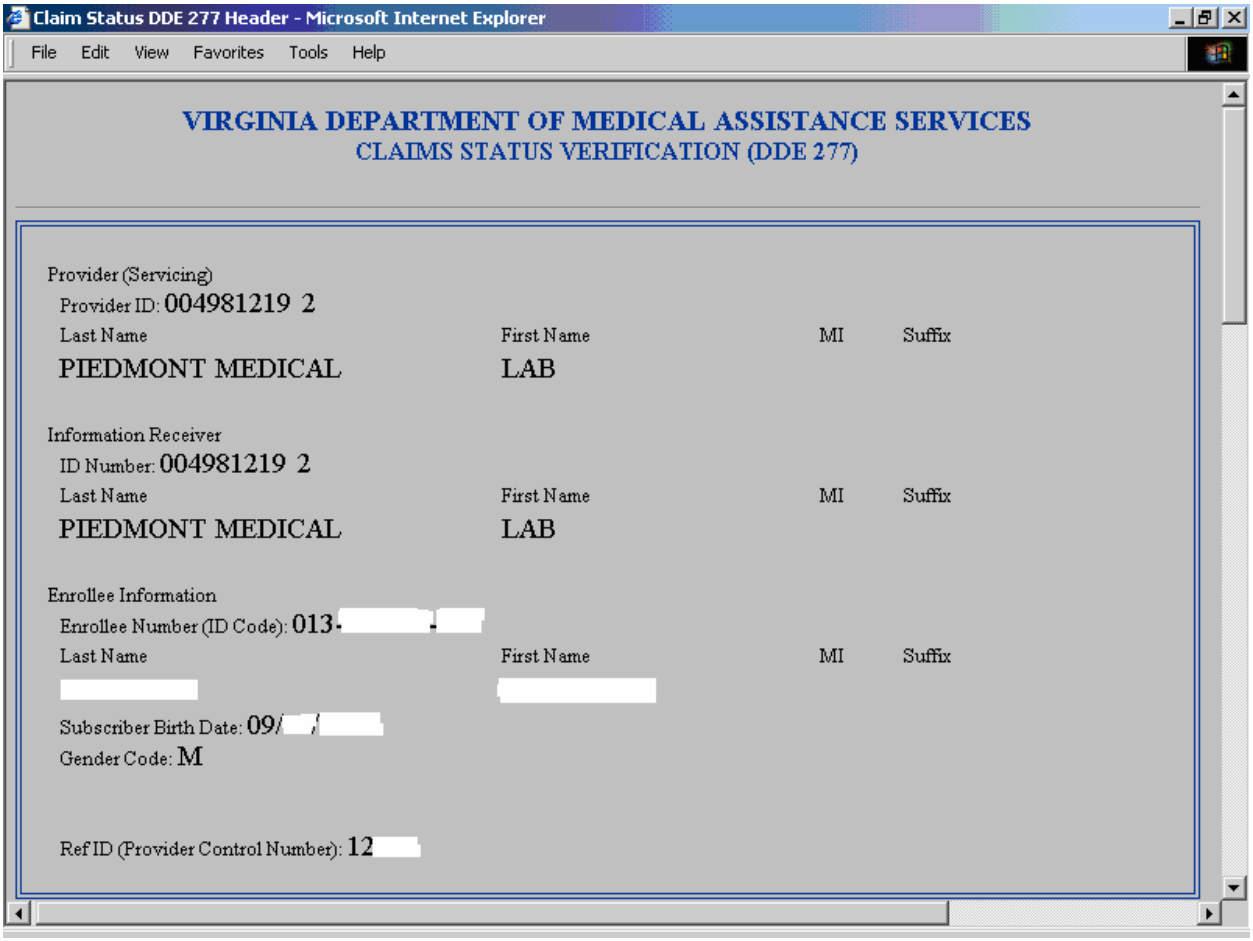


Please note, the Group Billing Practice must narrow its search for a any recipient claim(s) by placing the *Required* “Servicing Provider” number in the block provided on the Claims Status Verification (DDE 276) screen.

2b. Response Section:

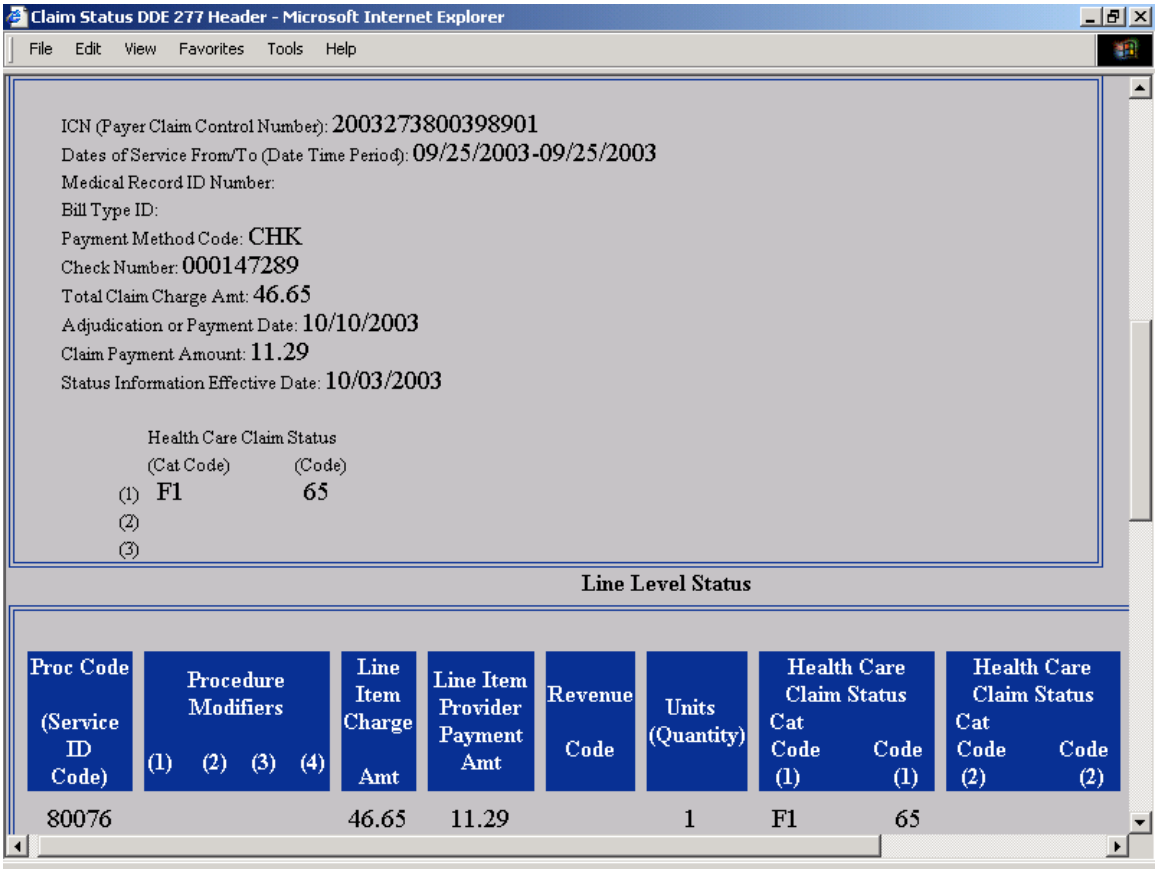
A claim search can return more than one claim. If this occurs, each claim will be displayed in a different claim level box. The same is true for line items; each line item will be displayed in a different status box. Below is a picture of the claims status verification response screen:

VIRGINIA DEPARTMENT OF MEDICAL ASSISTANCE SERVICES
CLAIMS STATUS VERIFICATION (DDE 277)



The transaction header box provides the Servicing Provider ID, Last Name (Business Name), First Name, Middle Initial, and Suffix. The same information is provided for the Information Receiver unless the inquiry is being made by the Group Billing Practice. If the Information Receiver is the Group Billing Practice then the Group Billing Practice ID Number and Name will be displayed. The Claims Status Verification (DDE 277) response will also provide the Enrollee Information: Enrollee Number (ID Code), Last Name, First Name, Middle Initial, Suffix, Subscriber Birth Date and Gender Code. At the bottom of the transaction header box is reflected the Provider Control Number entered on the Claims Status Verification (DDE 276).

Claim and Line Level Status Responses

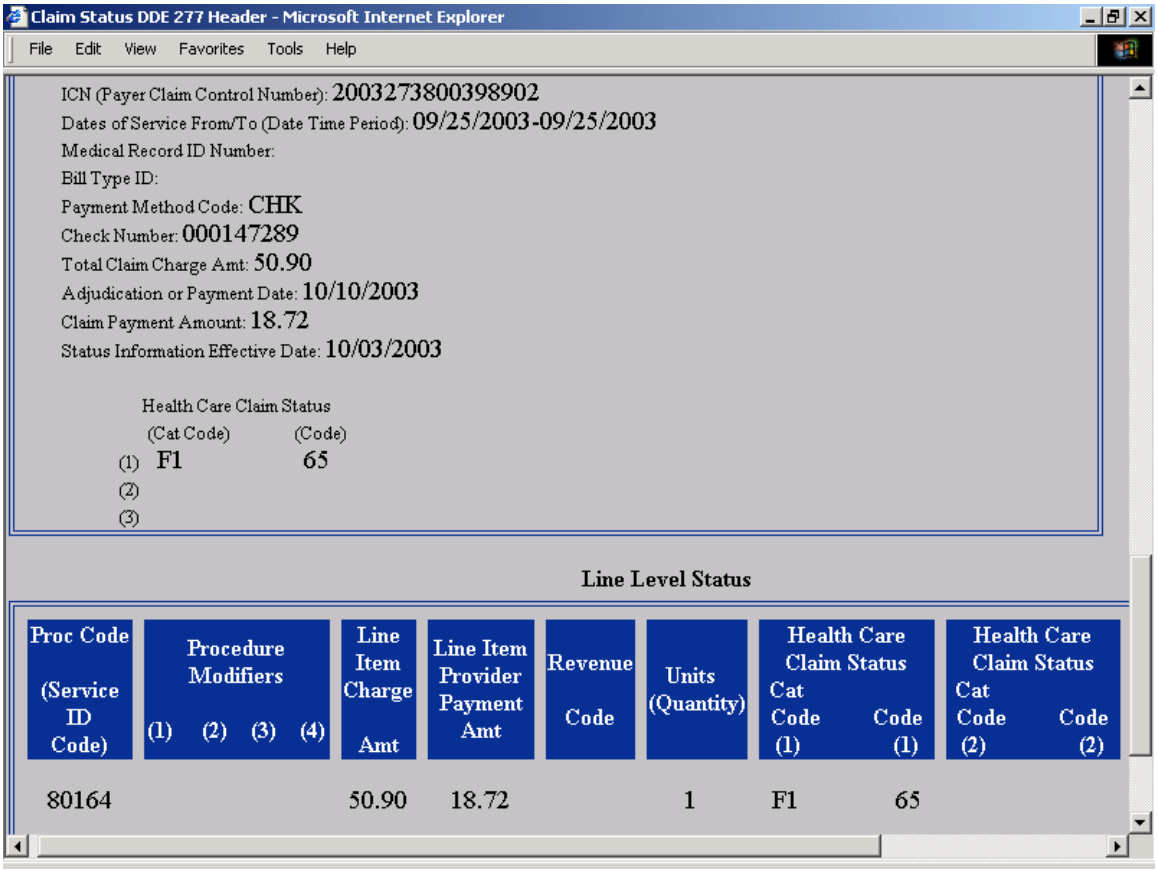


The Claim Status response returns the unique payer claim control number (ICN), the claim's Date of Services, Medical Record ID Number, Bill Type ID, Payment Method Code, Check Number, Total Claim Charge Amount, Adjudication or Payment Date, Claim Payment Amount, and the Status Information effective Date. The Health Care Claim Status Category Code and Claim Status Code are standard 837 response codes. These codes are available from the Washington Publishing Company at: http://www.wpc-edi.com/products/codelists/alertservice . The following matrix represents the default Claims Status Codes when more specific codes are unavailable.

Claim Status Category Code/Code

Disposition	Category Code	Status Code
Paid	F1	65
Denied	F2	9
TAD	P3	21
Adj/Void	F3	101
Pends	P2	** (Analysis in Progress)

Claim and Line Level Status Responses



The Line Level Status returns the Procedure Code (Service ID Code), Procedure Code Modifiers, Line Item Charge Amount, Line Item Provider Payment Amount, Revenue Code, Units (Quantity), Health Care Claim Status Category Code, and the Health Care Claim Status Code.

3. Prior Authorization Log

The Prior Authorization (PA) Log displays the requests for PA that a provider has submitted. The next two screens are used for PA requests. The first screen will prompt you to provide enrollee identification information. The second screen returns PA data pertaining to the enrollee identified in the query.

3a. Request Section

When this option is selected from the main menu, you will be prompted for the following information:

- Enter the Enrollee Number (ID Code) and the service dates
  - Service dates cannot span more than one month. If the service date is only one day, enter the same day in both fields. The first two fields hold a two-digit number for the month (MM) and day (DD), respectively. The third service date field holds a four-digit number for the year (CCYY). The service "from" date must be within one year from the current date. Future service dates are not allowed.

OR

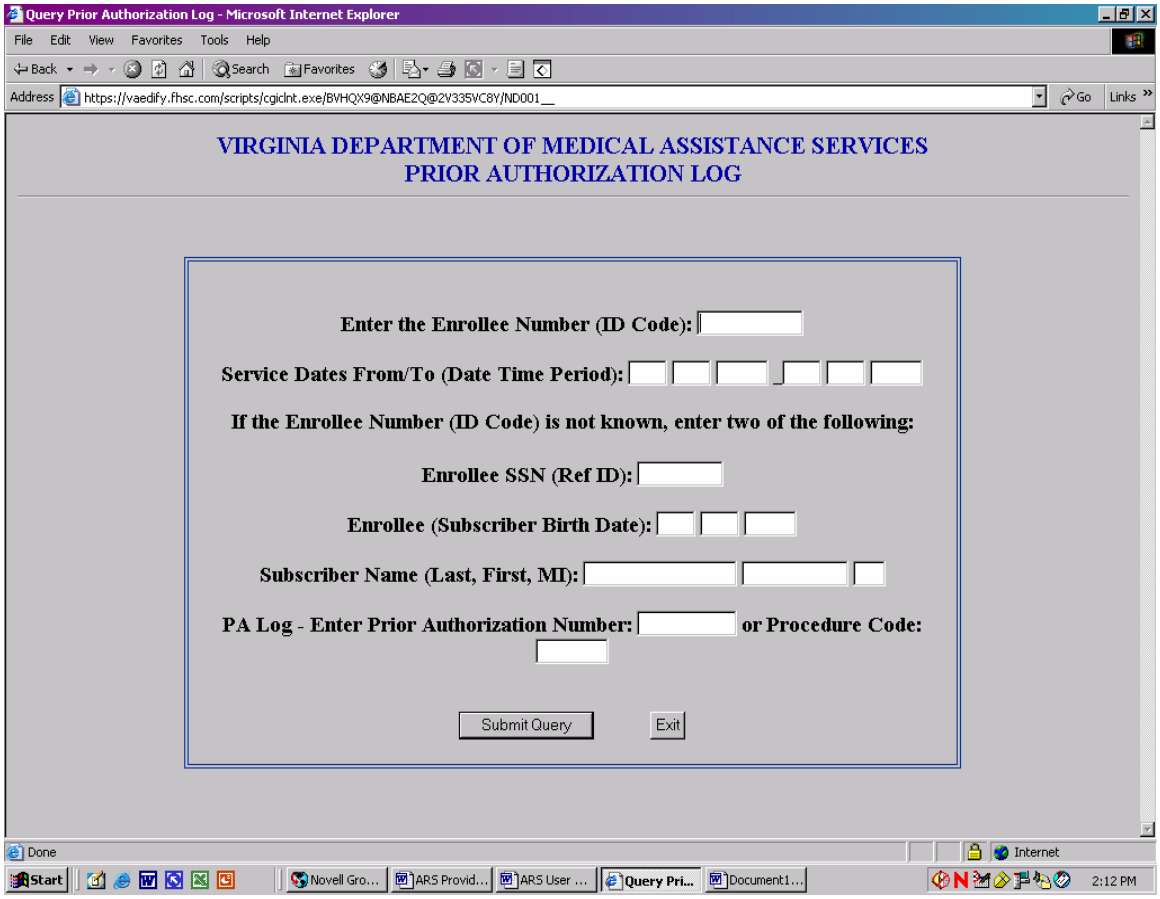
- Enter any two of the following:
  - Enrollee social security number (without dashes)
  - Enrollee date of birth (The first two fields hold a two-digit number for the month (MM) and day (DD), respectively. The third field holds a four-digit number for the year (CCYY))
  - Enrollee name (Middle initial is optional)
  - Prior authorization number assigned by DMAS
  - Procedure code (Standard HIPAA codes, up to seven characters)

NOTE: For field definitions, hold the cursor over a field for a few seconds and a brief description will appear. This description states the type of information that is required for that field (e.g. alphabetical, numeric) and the total number of characters that can be entered. When entering data into a field, an alpha/numeric character appears. This is the HIPAA field name and will not affect the information that is being submitted. Ignore this character.

Press "Submit Query" after entering the data. If any information entered is incorrect, a red error message will be displayed at the top of the form. Type in the correct information and resubmit.

Selecting "Exit" on this screen will take you out of ARS.

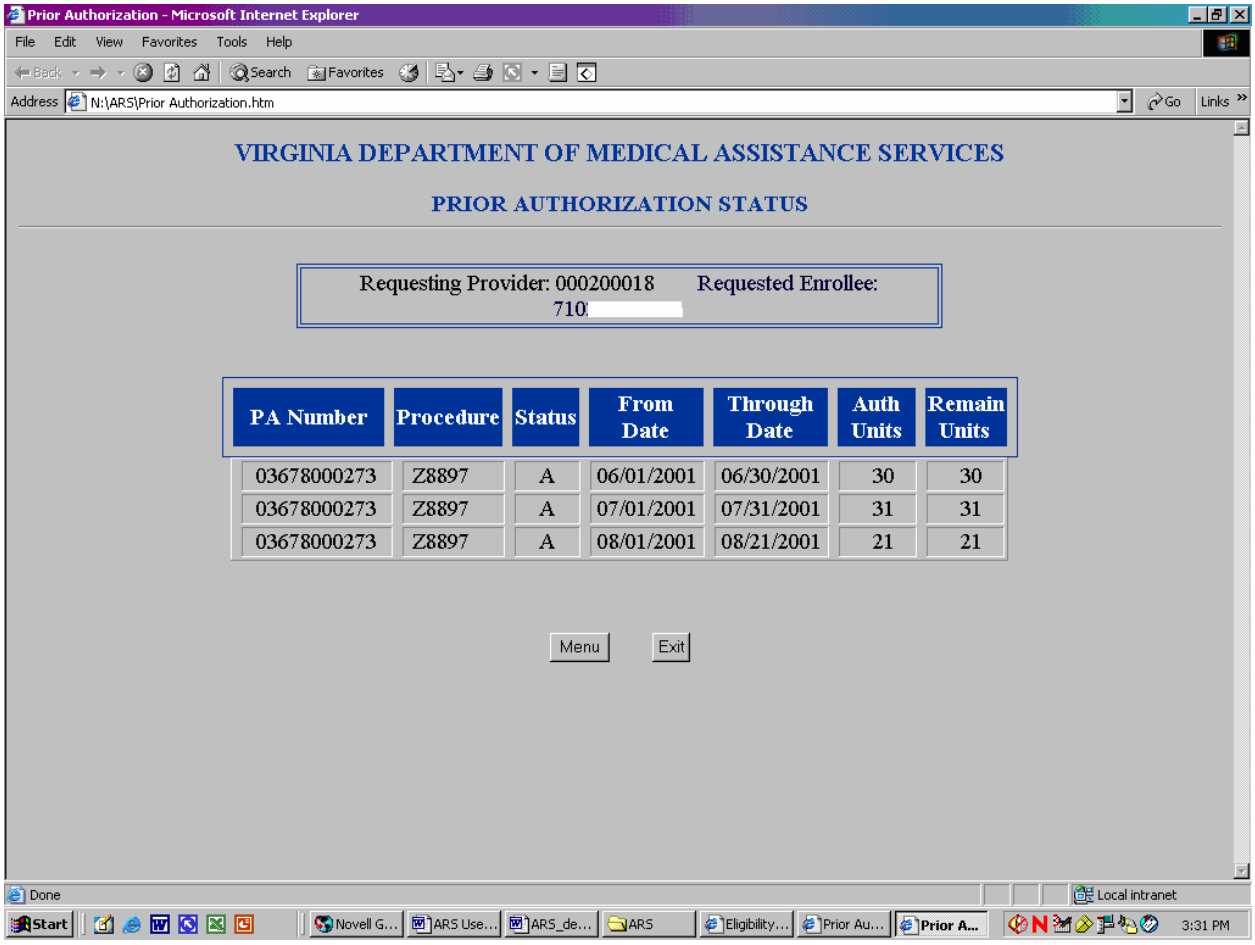
Below is a picture of the prior authorization log request screen:



3b. Response Section:

A prior authorization (PA) log search can return more than one PA. If this occurs, all of the PAs on record will be displayed.

Below is a picture of the prior authorization status response screen:



4. Provider Check Log

The Provider Check Log shows the check reimbursements made to the provider. The next two screens are used for check log requests. The first screen will prompt you to provide remittance information. The second screen returns all transactions pertaining to the given date.

4a. Request Section

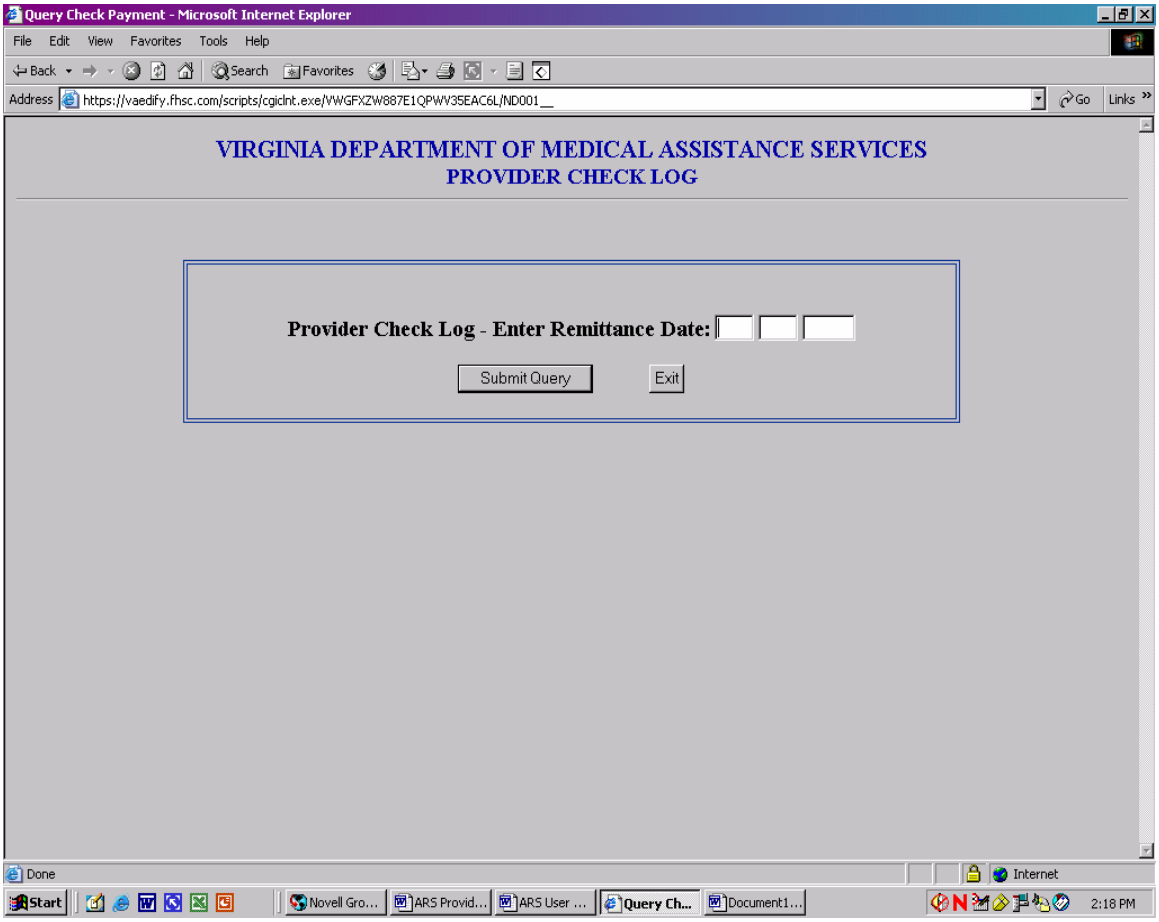
To request the check log, the provider must enter the remittance date. The first two fields hold a two-digit number for the month (MM) and day (DD), respectively. The third service date field holds a four-digit number for the year (CCYY).

NOTE: For field definitions, hold the cursor over a field for a few seconds and a brief description will appear. This description states the type of information that is required for that field (e.g. alphabetical, numeric) and the total number of characters that can be entered. When entering data into a field, an alpha/numeric character appears. This is the HIPAA field name and will not affect the information that is being submitted. Ignore this character.

Press “Submit Query” after entering the data. If the date is entered incorrectly, a red error message will be displayed at the top of the form. Type in the corrected date and resubmit.

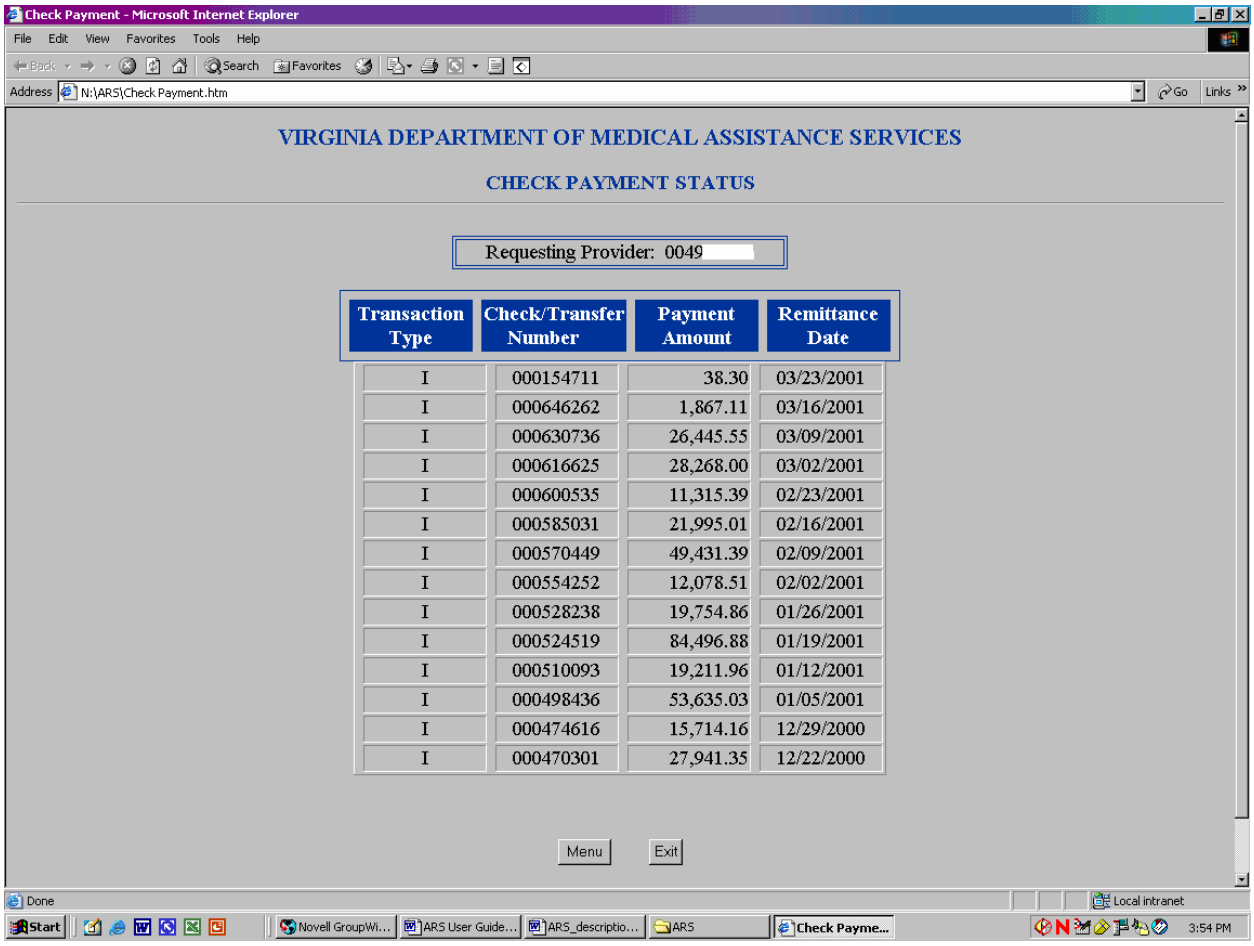
Selecting “Exit” on this screen will take you out of ARS.

Below is a picture of the provider check log request screen:



4b. Response Section:

The provider checklog displays all transactions for the given date. Below is a picture of the check payment response screen:



Transaction Type	Check/Transfer Number	Payment Amount	Remittance Date
I	000154711	38.30	03/23/2001
I	000646262	1,867.11	03/16/2001
I	000630736	26,445.55	03/09/2001
I	000616625	28,268.00	03/02/2001
I	000600535	11,315.39	02/23/2001
I	000585031	21,995.01	02/16/2001
I	000570449	49,431.39	02/09/2001
I	000554252	12,078.51	02/02/2001
I	000528238	19,754.86	01/26/2001
I	000524519	84,496.88	01/19/2001
I	000510093	19,211.96	01/12/2001
I	000498436	53,635.03	01/05/2001
I	000474616	15,714.16	12/29/2000
I	000470301	27,941.35	12/22/2000

5. Prescribing Provider ID Lookup

Only pharmacy providers are able to access this screen. The next two screens are used for requests for prescribing provider information. The first screen will prompt you to provide the prescribing provider ID. The second screen returns information pertaining to that prescribing provider.

5a. Request Section

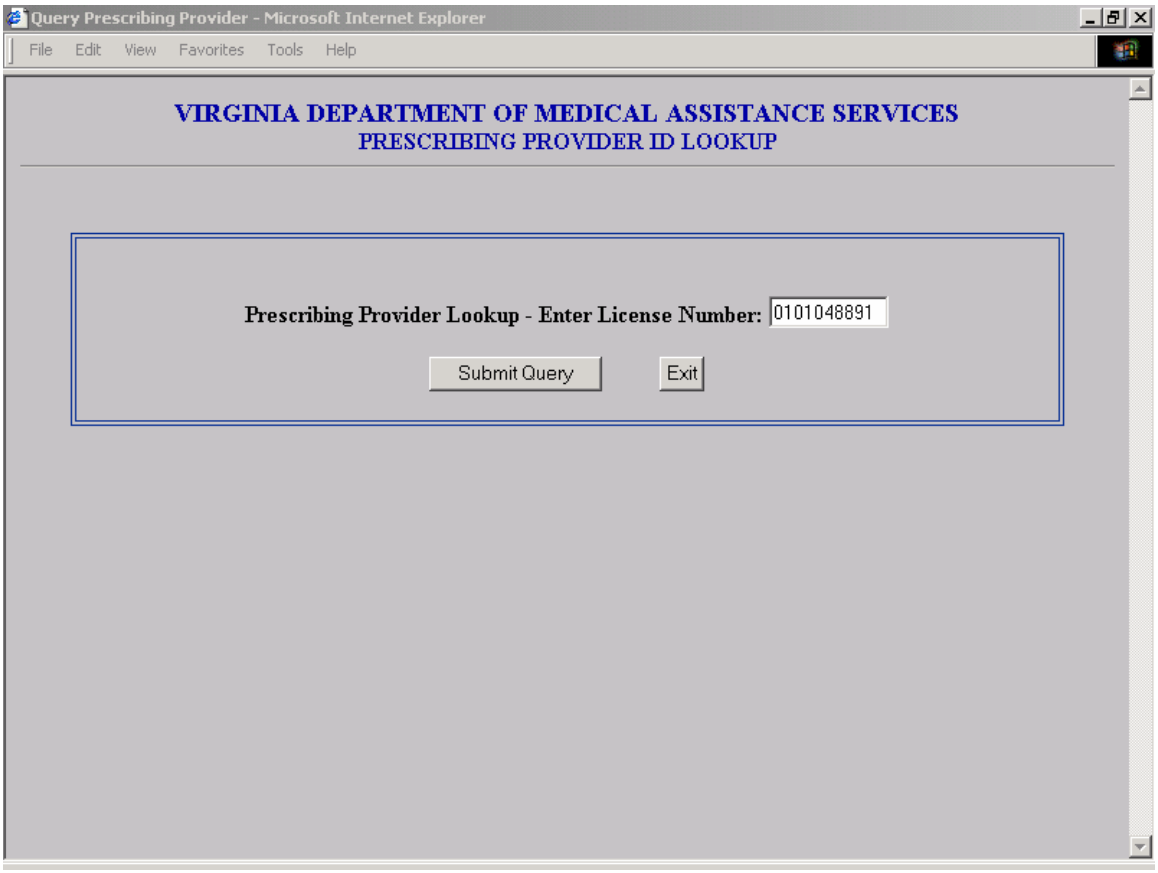
To request prescribing provider information, you must enter the ten-digit prescribing provider license number.

Press "Submit Query" after entering the data

Selecting "Exit" on this screen will take you out of ARS.

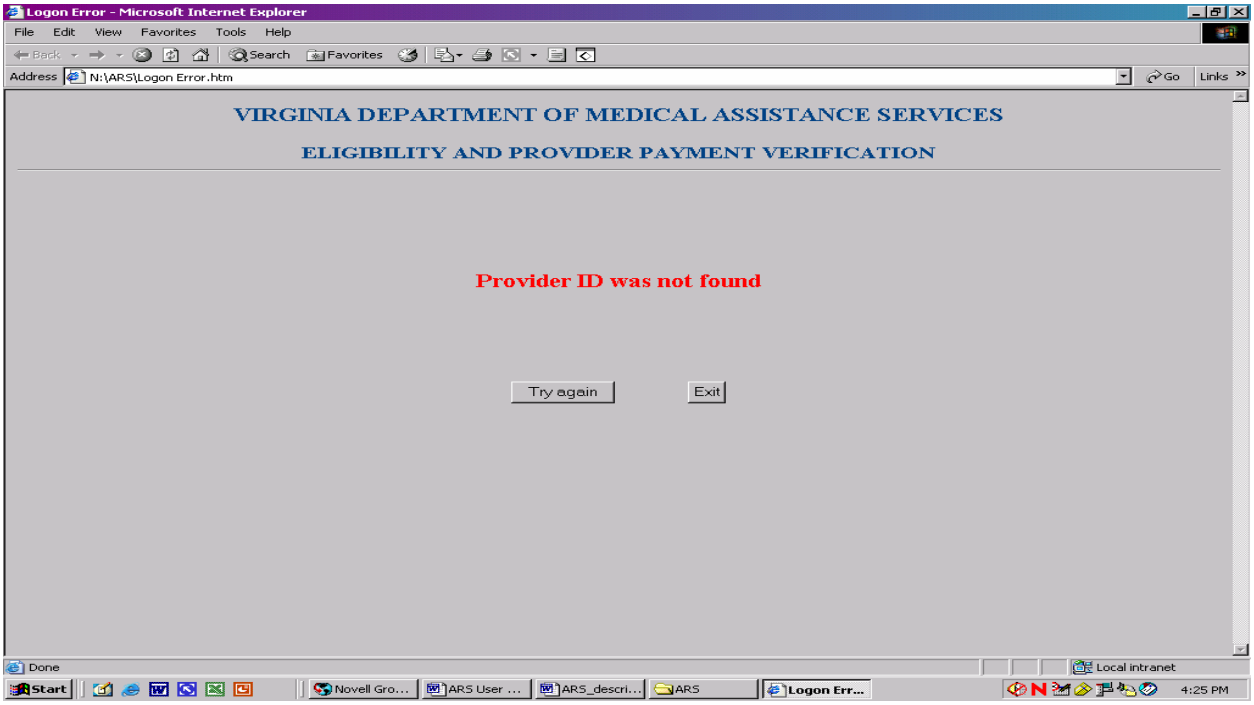
Below is a picture of the prescribing provider request screen:

VIRGINIA DEPARTMENT OF MEDICAL ASSISTANCE SERVICES
PRESCRIBING PROVIDER ID LOOKUP



NOTE: For field definitions, hold the cursor over a field for a few seconds and a brief description will appear. This description states the type of information that is required for that field (e.g. alphabetical, numeric) and the total number of characters that can be entered. When entering data into a field, an alpha/numeric character appears. This is the HIPAA field name and will not affect the information that is being submitted. Ignore this character.

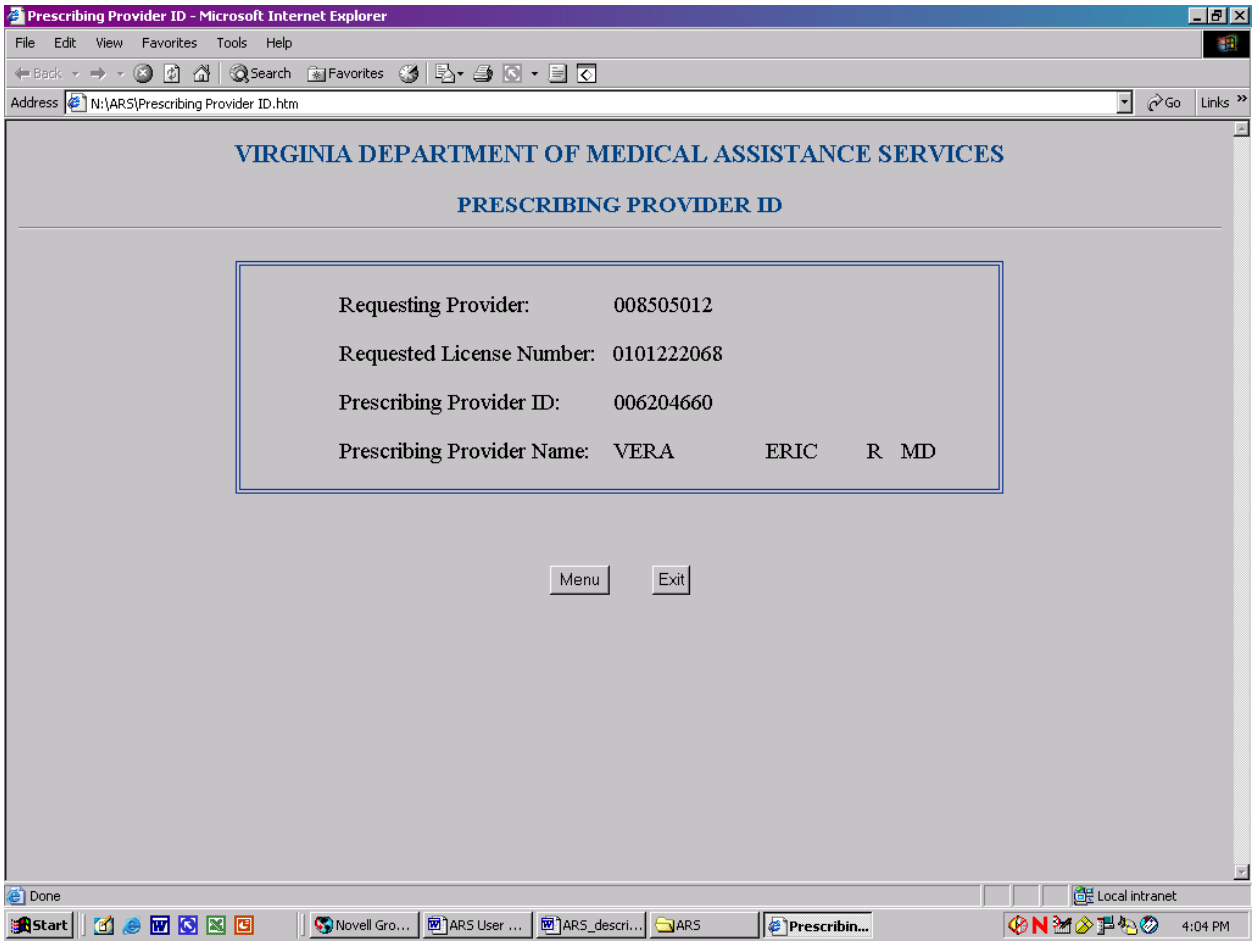
If the provider ID is incorrect or inactive, you will receive the following message:



Selecting “Exit” on this screen will take you out of ARS.

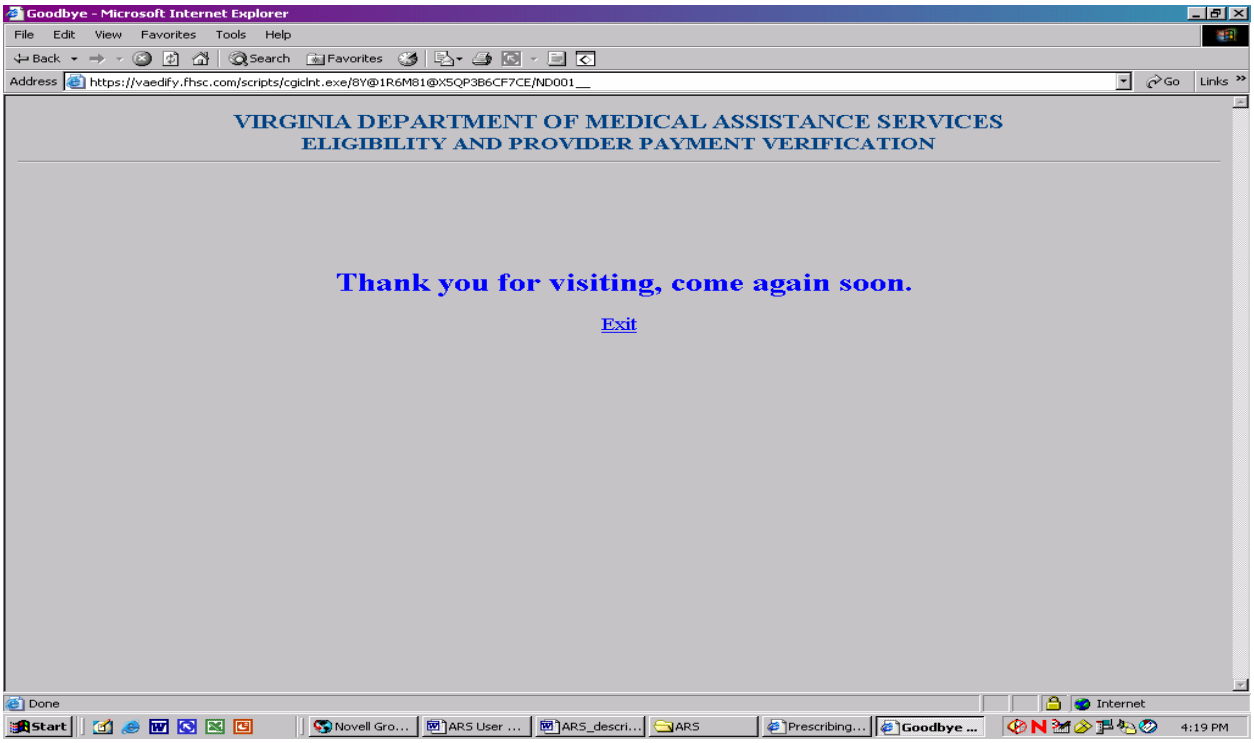
5b. Response Section:

Below is a picture of the prescribing provider ID response screen:

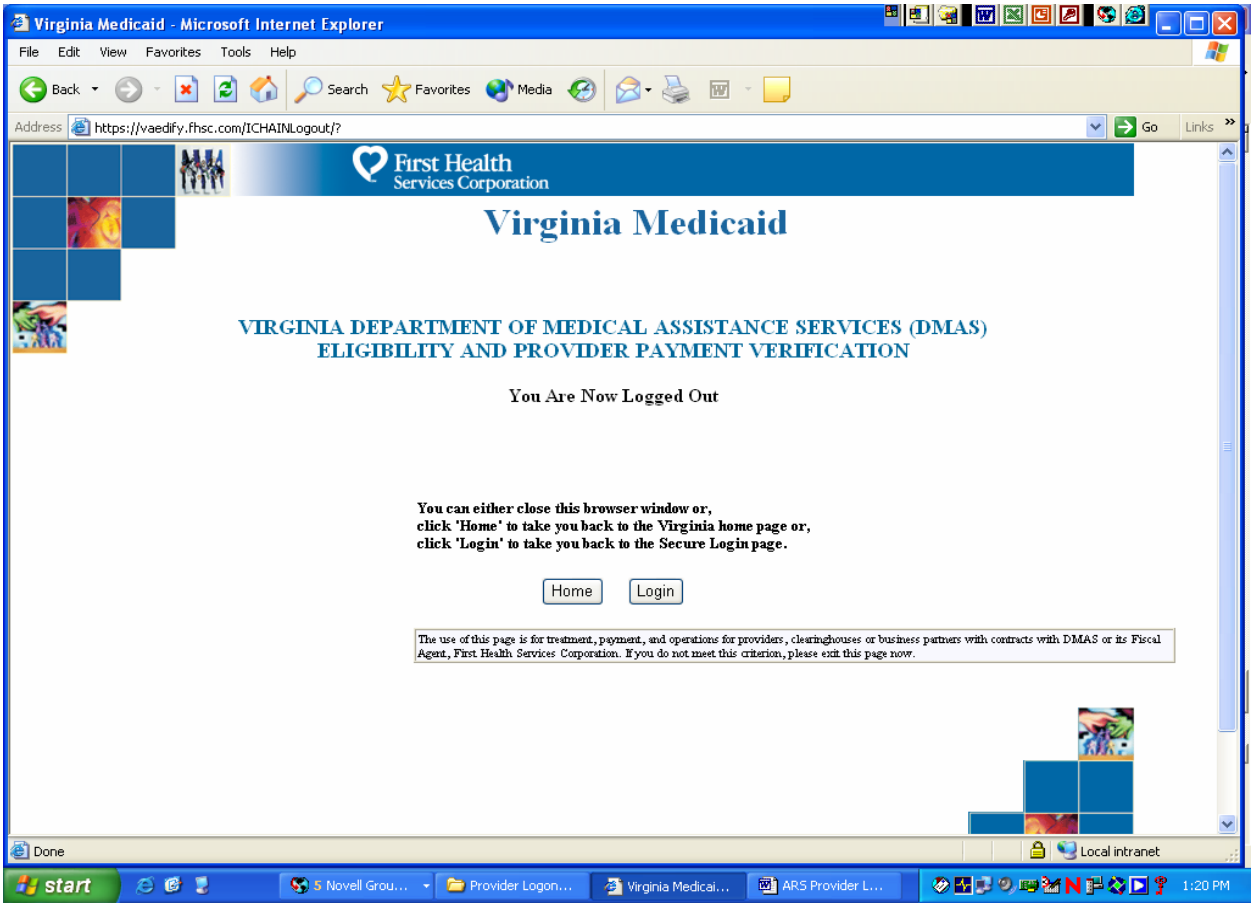


Exit Option

When “Exit” is selected from any screen within ARS, the following message will appear:



If “Exit” is selected again, the following message will appear and you will be logged out of ARS:



FAQ (FREQUENTLY ASKED QUESTIONS)

Registration Questions

Q. Why do I have to register for access to the online Eligibility and Provider Payment Verification?

A. The information that you are accessing is required to be secured under HIPAA regulations. The registration process allows verification that you as a provider are authorized to view this information.

Q. Once I register, how would I be contacted?

A. The Web Support Unit will contact you within 72 hours at the phone number that was provided as the contact number on the registration page.

Q. Who would I contact if I experience problems while enrolling?

A. Please contact the Web Support Unit at 1-800-241-8726.

Q. Do I need a separate logon ID and password for each member of my staff?

A. No. Each member of your staff can use the single logon ID and password assigned to your provider number.

General Questions

Q. Is the system HIPAA compliant?

A. Yes, HIPAA-covered portions of the system, 270/271 Eligibility and 276/277 Claims Status are HIPAA compliant. The HIPAA standards have an exception called Direct Data Entry (DDE). HIPAA-covered portions of the system do “use applicable data content and data conditions of the standard.”

Q. I handle claims for several providers. After checking claim status for one provider, how can I check claim status for another?

A. To logon as another provider, click the EXIT button until the Logged Out screen appears. Click on the LOGIN button to logon as a different provider.

Q. Little strings of letters sometimes appear when the mouse is placed over data or a data element name. What are they?

A. They are abbreviated field names applicable to the HIPAA DDE standard. They do not have meaningful business usage and should be ignored.

Q. What are Constant Reference Designators and Descriptions (in the box at the bottom of the Eligibility and Claims Status screens)?

A. Each HIPAA-covered screen displays the constant elements defined by the HIPAA 270/271 and 276/277 Implementation Guides. These fields are required in standard X12 transactions. They are not required to access the Eligibility and Provider Claims Verification systems and should be ignored.

Eligibility Verification and Service Limits Questions

Q. What service dates can I use?

A. The Service From Date must be 1 month or less before the Service To Date. Both service from and to date must be entered. The From Date cannot be more than 1 year in the past. The To Date cannot be in the future.

Q. What if I don’t know the enrollee number?

A. You may key in any two of the following: SSN, Birth Date or Name.

Q. What is the Provider's Control Number?

A. This is a tracking control number for internal purposes only. You are required to enter a value in this field. You might use your initials, the date, the medical record number, etc. Minimum length is one character.

Q. How do I inquire on service limits?

A. When you fill out the Eligibility inquiry screen, pull down the service limits box by clicking on the down arrow to the right of "For Service Limits enter Service Type Code."

Q. I've just found that a given enrollee is eligible. Can I check another enrollee?

A. Yes, just use your browser's Back button to get back to the screen where you keyed in the first enrollee's number. Delete that number and key in the new. You may also select the Menu button to return to the Eligibility Benefit Verification and Service Limits option.

Q. What is the meaning of the abbreviated Benefit Plan (Plan Coverage Desc) that is returned on the Eligibility DDE 271 screen?

A. Please use the matrix provided in Appendix A to clarify the meaning of the abbreviated Benefit Plan Short Name.

Claim Status Questions

Q. Do you show pended claims?

A. Yes.

Q. How does this compare with the HIPAA 835?

A. As a result of a claim, the 835 comes from First Health automatically in a batch of transactions. The 835 contains more information on claim status. This is not relevant to the inquiry on the web.

Q. What's an ICN?

A. It is the claim number assigned by First Health when the claim was received. Two years of claims history is available online in the ARS.

Q. What if I don't have the ICN?

A. Key in

- Enrollee Number and Service Dates OR
- Enrollee Number, Service Dates and Billing Provider.

Q. What dates can I use?

A. The Service From Date must be 1 month or less before the Service To Date. Both service from and to date must be entered. The From Date cannot be more than 2 years in the past. The To Date cannot be in the future.

Q. What is the Cat Code and Code?

A. The Health Care Claim Status Code (Code) and Category code (Cat Code) are converted from the claims disposition. The following Claims Status Codes represent the system defaults when more specific codes are not available:

Disposition	Cat Code	Code
Paid	F1	65
Denied	F2	9
TAD	P3	21
Adj/Void	F3	101
Pends	P2	

Prior Authorization (PA) Log Questions

Q. Can I authorize a procedure for a patient?

A. No, the PA Log is a historical list of PA's. In other words, the PA Log shows the results of previous, successful authorizations.

Provider Login Questions

Q. What is the format of my Provider Login Userid?

A. The Provider Login ID is an eleven-position number that consists of the provider number prefixed with "VA". If the provider number is only seven positions, then two (2) zeroes must be prefixed to the number between the "VA" and the seven position number. E.g. Provider number is "1234567" then the Provider's Login ID will be "VA001234567" for a total of 11 positions.

Q. How do I login as a different provider?

A. Upon clicking the EXIT button within the Virginia Department of Medical Assistance Services – Eligibility and Provider Payment Verification System, A LOGGED OUT page will display. Click on the LOGIN button. The LOGIN page will display and allow you to login again as a different provider.

Q. How do I stop the display of the Security Alert screen?

A. Click the button that states, 'Do Not Show This Screen Again".

Q. Who would I contact if I experience problems while trying to log in?

A. Please contact the Web Support Unit at 1-800-241-8726.

Q. When attempting to login, I received a screen with a message, 'This Page Can Not Be Displayed'. What does this mean?

A. There are several reasons for this message:

- You may not have the latest version of the browser. 128 bit is required. Follow your company procedures to have the newest version of the browser installed.
- Your internet connection may be down or disconnected.
- The FHSC network may be down. Contact the WSU at 1-800-241-8726.

Q. Is there any cost for using the Eligibility and Provider Payment Verification system?

A. No, all costs are absorbed by CMS and the Commonwealth.

Q. I tried an incorrect password 3 times and now I am unable to log on?

A. This is a security measure to avoid hacking. To have your password reset, please contact the WSU at 1-800-241-8726. You will be asked questions to verify your identity.

Q. I registered 3 days ago and have not heard anything. What is the next step?

A. The First Health WSU has peak demands at times. Do not re-register. Contact the WSU at 1-800-241-8726.

Q. My password doesn't work.

A. The password is case sensitive. If necessary, turn your Caps Lock key (on your keyboard) off. For example, "GetBetter" is different from "GETBETTER." If you are unable to resolve, then contact the WSU at 1-800-241-8726

Q. I forgot my password.

A. Contact the WSU at 1-800-241-8726. You will be given a new password that must be changed the first time you attempt to use it.

Q. After registering as a new provider, I was contacted by First Health Web Support Unit and was instructed to change my password when I login the very first time. How is this done?

A. On the Login web page, enter your login userid and password that was assigned to you by the WSU. Another page will display that will ask you to change your password. Enter your old password, your new password and, for verification purposes, your new password again. Click the SUBMIT button.

Q. After I changed my password, the Login page was displayed again. What should I do?

A. Key your login userid and new password and click the SUBMIT button. You will be directed to the Eligibility and Provider Payment Verification System.

APPENDIX A

Short Name – Benefit Plan (Plan Coverage Description)

Medicaid FFS – Medicaid Fee-For-Service
FAMIS Plus – Children Enrolled in Medicaid
XIX Central – Medicaid, Medallion II Central Area
XIX CMM Phys – Medicaid, Client Medical Management Physician
XIX CMM Rx – Medicaid, Client Medical Management Pharmacy
XIX CMM Tran – Medicaid, Client Medical Management Transportation
XIX Def. MCO – Medicaid, Default Mandatory Managed Care Organization
XIX FFS Emer – Medicaid, Fee-For-Service Emergency Services Only
XIX FFS Dial – Medicaid, Fee-For-Service Dialysis Services Only
XIX Halifax – Medicaid, Medallion II Halifax County
XIX ICF – Medicaid, Intermediate Care Facility
XIX LS Hosp – Medicaid, Long Stay Hospital
XIX M-3 CDPR – Medicaid, Medallion III Charlottesville, Danville, Pittsylvania Region
XIX M-3 LSWV – Medicaid Medallion III Lower Southwest Virginia Region
XIX M-3 MCO – Medicaid, Default Medallion III Managed Care Organization
XIX M-3 Nor VA – Medicaid, Medallion III Managed Care Organization Northern Virginia Area
XIX M-3 PCP – Medicaid, Medallion III MEDALLION PCP
XIX PCP – Medicaid, MEDALLION Primary Care Provider (PCP)
XIX SNF – Medicaid, Skilled Nursing Facility
XIX Tidewtr – Medicaid, Medallion II Tidewater Area
XIX USWVA – Medicaid, Medallion II Upper Southwest Virginia Area

ASM ACR ASSM – ACR, Adult Care Residence Assessments
ASM NH LVL 1 – Assessments Nursing Home Level 1
ASM NH LVL 2 – Assessments Nursing Home Level 2
AIDS Waiver – AIDS Waiver
Aged Waiver – Elderly and Disabled Waiver
CDPAS Waiver – Consumer Directed Program Waiver
Fmly Pln Wvr – Family Planning Waiver
HIV Premium – HIV Premium
HIPP Premium – Health Insurance Premium Payment
HIDP – Health Insurance Demonstration Program
Hospice – Hospice Program
IFDSS Waiver – IFDSS Waiver
Intensive AL – Intensive Assisted Living
Med Co & Ded – Medicare Coinsurance & Deductibles
Med Premium – Medicare Premium
MR Waiver – Mental Retardation Waiver
Pre-PACE – Pre Program of All Inclusive Care for the Elderly
PACE – Program of All Inclusive Care for the Elderly
Prt Med Prem – Partial Medicare Premium
Reg Assist L – Regular Assisted Living
Regular AL – Regular Assisted Living
SLH – State and Local Hospitalization
TDO – Temporary Detention Order
Vent Waiver – Technology Assisted Waiver

FAMIS CMM Py – FAMIS, Client Medical Management Physician
FAMIS CMM Rx – FAMIS, Client Medical Management Pharmacy
FAMIS Centra – FAMIS, Medallion II Central Virginia Region
FAMIS-CDPR – FAMIS, Medallion II Charlottesville, Danville, Pittsylvania Region
FAMIS FFS – FAMIS, Fee-For-Service
FAMIS-Halr – FAMIS, Medallion II Halifax County
FAMIS HIPP P – FAMIS, HIPP Premium Payments
FAMIS ICF – FAMIS, Intermediate Care Facility

FAMIS LS Hos – FAMIS, Long Stay Hospital
FAMIS-LSWV – FAMIS, Medallion II Lower Southwest Virginia
FAMIS-MCO – FAMIS, Default Mandatory Managed Care Organization
FAMIS M3 MCO – FAMIS, Default Medallion III Managed Care Organization
FAMIS NorVA – FAMIS, Medallion II Northern Virginia Region
FAMIS OS Prv – FAMIS, Out of State Provider
FAMIS PCP – FAMIS, MEDALLION PCP
FAMIS Reg AL – FAMIS, Regular Assisted Living
FAMIS SNF – FAMIS, Skilled Nursing Facility
FAMIS Tr – FAMIS, Transportation
FAMIS Tidewr – FAMIS, Medallion II Tidewater Region
FAMIS-USWV – FAMIS, Medallion II Upper Southwest Virginia

GLOSSARY

Benefit Plan: plan coverage description. See Appendix A for a complete list of plans and there abbreviations.

Carrier Name: name of the TPL carrier.

Claim Payment Amount: actual amount paid by DMAS

Constant Reference Descriptor and Descriptions: standard constant fields as defined by the HIPAA 270/271 and 276/277 Implementation Guides. These fields are typically HIPAA required fields, with a constant value unrelated to the Virginia MMIS application.

Health Care Claim Status (Cat Code): the category code under which the status falls. See Appendix A for a complete list of Claims Status Category Codes.

Health Care Claim Status (Code): the code under which the status falls. See Appendix A for a complete list of Claims Status Codes.

ICN (Payor Claim Control Number): the claim identifier assigned by DMAS

Line Item Charge Amount: actual **a**mount charged by provider for a given service

Line Item Provider Payment Amount: actual amount paid by DMAS for a given service

Originating Company Number: a HIPAA required field. The intent is for systems that pass transactions multiple companies and multiple systems. It does not apply to this application. The provider number used at logon populates this field.

Payer's Control Number: a HIPAA required trace code. The user must enter a value that is then returned on the response screen. The system does nothing else with the value.

Procedure Code (Service ID Code): the standard HIPAA codes, up to seven characters.

Provider's Control Number: a tracking control number for internal purposes only. It is a required field. It can be a patient account number, a date and time, or any other alphanumeric code chosen by the provider to track this inquiry.

Remittance Date: the date the payment was made

Total Claim Charge Amount: actual amount charged by provider

Verification Number: a number returned by the MMIS that confirms the provider received a confirmation for enrollee eligibility. The provider may use it as an official reference number in the future.